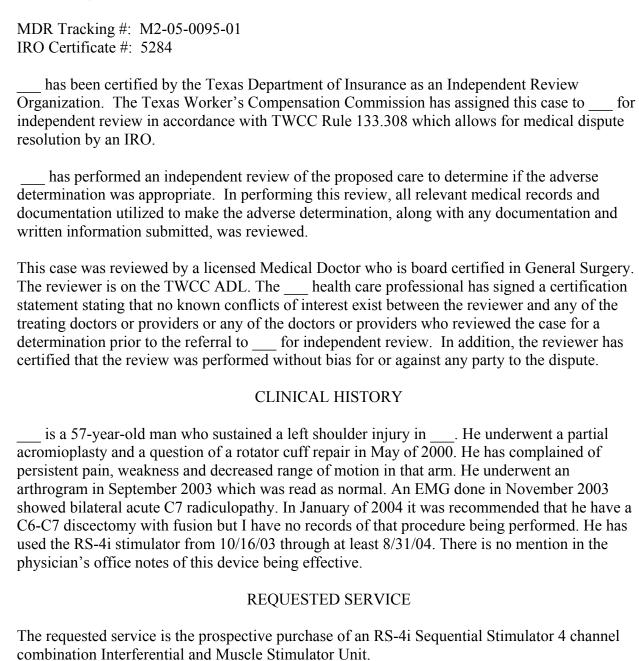
October 27, 2004



DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer indicates that there is no published data on the efficacy of this device, or devices of this type, for treatment and rehabilitation of shoulder pain. As such, this has to be considered unproven and/or experimental treatment. (Managing musculoskeletal complaints with rehabilitation therapy; summary of the Philadelphia Panel evidence based clinical practice guidelines on musculoskeletal rehabilitation interventions. Harris GR, Susman JL. J Fam Pract. 2002 Dec;51 (12):1042-6.)

The reviewer further indicates that published data with regard to back pain utilizing similar modalities, such as spinal cord stimulation, fail to show any significant benefit from long term use of these devices. There is only modest clinical improvement when this modality is used in conjunction with physical therapy as compared with physical therapy alone, which diminishes over 6-12 months (Spinal cord stimulation for patients with failed back surgery syndrome or complex regional pain syndrome: a systematic review of effectiveness and complications. Turner JA, et al Pain. 2004 Mar; 108 (1-2):137-47. Spinal cord stimulation for complex regional pain syndrome: an evidence based medicine review of the literature. Grabow TS, et al Clin J Pain. 2003 Nov-Dec; 19(6):371-83).

has performed an independent review solely to determine the medical necessity of the health
services that are the subject of the review has made no determinations regarding benefits
available under the injured employee's policy believes it has made a reasonable attempt to
obtain all medical records for this review and afforded the requestor, respondent and treating
doctor an opportunity to provide additional information in a convenient and timely manner.
As an officer of, I certify that there is no known conflict between the reviewer, and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.
Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 28th day of October 2004.